THE WASHINGTON STATE POLST PROGRAM FOR EMS PROVIDERS

DOH 530-264 July 2024

Cognitive Objectives

- Describe the 1992 amendment to Washington's Natural Death Act.
- Recognize the liability for EMS personnel regarding the POLST or other valid resuscitation orders.
- Describe the philosophy of the POLST program.
- Describe what the POLST form is.
- Describe what the POLST form does.
- Describe who qualifies to have a POLST form.
- Describe what is required for the POLST form to be valid.

Cognitive Objectives

- Describe how the POLST form is transferred from one setting to another.
- Recognize the POLST form and other valid resuscitation orders.
- Recognize the parts of the POLST form.
- Recognize when an individual has revoked the POLST form or other valid resuscitation orders.

Cognitive Objectives

- Describe who keeps the POLST form and where the POLST form is kept.
- Describe how to manage an individual with a POLST form or other valid resuscitation orders.
- Describe how to document a POLST or other valid resuscitation order on the patient care report.
- Describe how to provide comfort care measures to a dying individual.

Affective Objectives

- Explain which individuals qualify for the POLST program.
- Explain the steps you can use to communicate with grieving family members.

Psychomotor Objectives

- Locate and identify the POLST form or other valid resuscitation orders.

History & Philosophy of the POLST Program

Legislative Directive

In March of 1992, the state legislature directed the Washington State Department of Health to adopt guidelines for how EMS personnel should respond to written do not resuscitate (DNR) orders.

Washington State Department of
HEALTH

RCW 18.71.210

- Provides protection for all acts and omissions done in good faith.
- In honoring POLST, the EMS provider will be acting in good faith by:
  - Following MPD protocol
  - Following the patient's Medical Provider's Orders

Patient Rights

Having the ability to indicate their decisions about life-sustaining treatment.

Have a mechanism in which individuals could describe their desires for life-sustaining treatment to healthcare providers.

Have healthcare providers who understand how to provide comfort care while honoring the individual’s desires for life-sustaining treatment.

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

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: See page 2 for complete instructions.

MEDICAL CONDITIONS/INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A CHECK ONE

Use of Cardiopulmonary Resuscitation (CPR): When the individual has NO pulse and is not breathing.

- ☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*
- ☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B CHECK ONE

Level of Medical Interventions: When the individual has a pulse and/or is breathing.
Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

- ☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below. *Transfer to hospital if indicated. Includes intensive care.*
- ☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below. *Transfer to hospital if indicated. Avoid intensive care if possible.*
- ☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort. *Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.*

Additional orders (e.g., blood products, dialysis):

C

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with:
- ☐ Individual ☐ Parent(s) of minor
- ☐ Guardian with health care authority
- ☐ Legal health care agent(s) by DPOA-HC
- ☐ Other medical decision maker by 7.70.065 RCW

SIGNATURE – MD/DO/ARNP/PA-C (mandatory)	DATE (mandatory)
PRINT – NAME OF MD/DO/ARNP/PA-C (mandatory)	PHONE

SIGNATURE(S) – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) (mandatory)	RELATIONSHIP	DATE (mandatory)
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) (mandatory)		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

WSMA Washington State Medical Association
Washington State Department of Health

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit www.wsma.org/POLST.

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The POLST Form

What is the POLST form?

Easily identifiable — bright, lime green

Portable — goes with the individual from one care setting to another

Summary of treatment preferences — Easy to read in an emergency situation

Describes the individual’s care directions — Patient care preferences

Patient’s medical provider’s orders

What does the POLST form do?

Allow patients and their medical providers to discuss and develop plans to reflect the individual’s end of life care wishes.

Assists medical providers in honoring the individual’s wishes for life-sustaining treatment.

Directs appropriate treatment by EMS personnel.

Who qualifies to utilize the POLST form?

- Anyone can qualify for a POLST.
- It must be signed by the individual's medical provider.
- It is most relevant to those with a serious health condition or those who would like to place limitations on the emergency medical care they may receive.

What is required for the POLST form to be valid?

- Patient’s name
- Patient’s date of birth
- Patient’s or legal medical decision maker’s signature and date
- Medical provider signature date
- ALL copies, digital images, and faxes of completed and signed POLST forms are valid

Where is a POLST form used?

Everywhere.

The completed POLST form is a medical provider order form that remains with an individual when transported between care settings, regardless of whether the setting is a person's home, a long-term care facility, or a hospital.

How is the POLST form transferred?

- The original form remains in the possession of the patient.
- Original, photocopies, digital images, and faxes of signed POLST forms will be honored.
- Duplicated copies may be placed in the patient’s chart upon discharge or before interfacility transports.
- HIPAA permits disclosure of POLST to other healthcare providers as necessary.

Who keeps the POLST form & where is it kept?

In the Home:

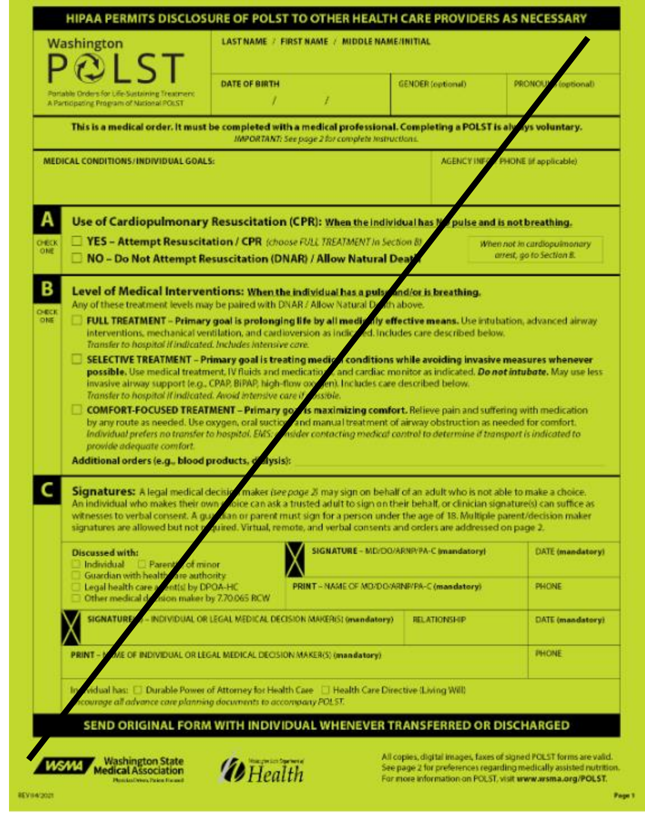
- Kept by the patient
- Placed in a prominent location:
  - Next to the front door
  - On or in the refrigerator
  - Look for a Vial of Life or other container

At a medical facility:

- Kept by the facility staff
- Placed in the patient's medical chart

Revocation of the POLST form

- A POLST form may be revoked by:
  - The individual verbally revoking the order
  - The individual destroying the form
  - The individual drawing a diagonal line or the word VOID across the front of the form
  - The medical providers by expressing the patient's revocation of the order
  - The legal medical decision maker



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

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL

DATE OF BIRTH / /

GENDER (optional)

PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: See page 2 for complete instructions.

MEDICAL CONDITIONS/INDIVIDUAL GOALS:

AGENCY INFO/PHONE (if applicable)

A CHECK ONE
Use of Cardiopulmonary Resuscitation (CPR): When the individual has NO pulse and is not breathing.
- ☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*
- ☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B CHECK ONE
Level of Medical Interventions: When the individual has a pulse and/or is breathing.
Any of these treatment levels may be paired with DNAR / Allow Natural Death above.
- ☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below. *Transfer to hospital if indicated. Includes intensive care.*
- ☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below. *Transfer to hospital if indicated. Avoid intensive care if possible.*
- ☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. *Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.*

Additional orders (e.g., blood products, dialysis):

C
Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with:
- ☐ Individual ☐ Parent(s) of minor
- ☐ Guardian with health care authority
- ☐ Legal health care agent(s) by DPOA-HC
- ☐ Other medical decision maker by 7.70.065 RCW

X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)** | DATE **(mandatory)**

PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)** | PHONE

X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)** | RELATIONSHIP | DATE **(mandatory)**

PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)** | PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

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Washington State Department of Health

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Page 1

An individual’s wish to withhold resuscitation should always be respected.

A Special Situation:

When the family vigorously and persistently insists on CPR, even if a valid POLST order is located:

- Attempt to convince the family to honor the individual's decision to withhold CPR. If the family persists, then;
  - Initiate resuscitation efforts until relieved by advanced level providers.
  - Continue treatment and consult medical control.

Other valid resuscitation orders

- Verify the order has a medical provider signature requesting "Do Not Resuscitate."
- Verify the presence of the individual's name on the order.
- Contact on-line medical control for further consultation.

Next Steps

Always refer to local protocols

Providing Comfort Care

- Manually open the airway.
- Clear the airway of secretions with an appropriate suction device.
- Provide oxygen via nasal cannula at 2-4 liters per minute.
- Positioning for comfort.
- Splinting.
- Controlling bleeding.
- Providing pain medications pertinent to the level of certification/licensure.
- Provide emotional support to the individual and family
- Always refer to local protocols

Run report documentation

Complete	Identify	Follow
Complete a medical incident report form.	Identify the individual as having a valid POLST form.	Follow your local MPD protocols for individuals who have died.

Support grieving family members

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

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

How best to tell the worst news

- One EMS provider on the team takes the lead.
- Get yourself ready.
- Gather information about the death.
- Find a quiet location.
- Get physically lower.
- Nonverbal actions speak louder than words.

How best to tell the worst news

- Listen, and be still.
- Use physical touch when appropriate.
- Briefly review the history and circumstances.
- Use the word “death” or “dead.”
- Expect any reaction and allow time to express anguish.
- Convey sympathy for a grieving family.

How best to tell the worst news

- Find someone to be with them during this time.
- Offer an opportunity to say goodbye to their loved one.
- Tell them the plan for disposition of the body.
- Ask if they have any questions. Answer them directly.
- Don’t lie.
- Leave clear information about follow-up contacts.

POLST FORM CONTENTS

Individual Information

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

Washington POLST Portable Orders for Life-Sustaining Treatment A Participating Program of National POLST	LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
	DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT:* *See page 2 for complete instructions.

MEDICAL CONDITIONS / INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

Medical Conditions/Patient Goals

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

Washington POLST Portable Orders for Life-Sustaining Treatment A Participating Program of National POLST	LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
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IMPORTANT: See page 2 for complete instructions.

MEDICAL CONDITIONS / INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

Section A – Cardiopulmonary Resuscitation (CPR)

A	Use of Cardiopulmonary Resuscitation (CPR): <u>When the individual has NO pulse and is not breathing.</u>	
CHECK ONE	☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)* ☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**	*When not in cardiopulmonary arrest, go to Section B.*

Section B: Level of Medical Interventions

B	**Level of Medical Interventions: When the individual has a pulse and/or is breathing.**
	Any of these treatment levels may be paired with DNAR / Allow Natural Death above.
CHECK ONE	☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below. *Transfer to hospital if indicated. Includes intensive care.*
	☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below. *Transfer to hospital if indicated. Avoid intensive care if possible.*
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	Additional orders (e.g., blood products, dialysis): ________________

Section C: Signatures

C

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with:
- ☐ Individual ☐ Parent(s) of minor
- ☐ Guardian with health care authority
- ☐ Legal health care agent(s) by DPOA-HC
- ☐ Other medical decision maker by 7.70.065 RCW

X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**	DATE **(mandatory)**
PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**	PHONE

X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**	RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)

Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Example of Signature Box

C

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with:
- ☐ Individual ☐ Parent(s) of minor
- ☐ Guardian with health care authority
- ☐ Legal health care agent(s) by DPOA-HC
- ☐ Other medical decision maker by 7.70.065 RCW

X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**
Jennifer Smith, MD

DATE **(mandatory)**
06/17/2021 - 1300

PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**
Jennifer Smith, MD

PHONE

X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**
[Leave Blank for Signature] Mary Davis, RN
Davis, RN

RELATIONSHIP

DATE **(mandatory)**
06/17/2021 - 1300

PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**
Frank Miller (Patient) OR Susan Miller (POA) Verbal Consent by Patient or POA/M.Davis

PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Example of Signature Box #2

C

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with:	SIGNATURE – MD/DO/ARNP/PA-C **(mandatory)**	DATE **(mandatory)**
☐ Individual ☐ Parent(s) of minor ☐ Guardian with health care authority ☐ Legal health care agent(s) by DPOA-HC ☐ Other medical decision maker by 7.70.065 RCW	X [Leave Blank for Signature] *Mary Davis, RN*	06/17/2021 - 1300
	PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)** Jennifer Smith, MD - T.O. Mary Davis, RN	PHONE

SIGNATURE(S) – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**	RELATIONSHIP	DATE **(mandatory)**
X *Frank Miller* OR "Verbal Consent from [Patient/Surrogate Name]" *Mary Davis, RN*		06/17/2021 - 1300
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)** Frank Miller (Patient) OR Susan Miller (Legal Medical Decision Maker/Surrogate)		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)

Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Page 2 - for EMS awareness

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

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		DATE OF BIRTH / /
Additional Contact Information (if any)		
LEGAL MEDICAL DECISION MAKER(S) (by DPOA-HC or 7.70.065 RCW)	RELATIONSHIP	PHONE
OTHER CONTACT PERSON	RELATIONSHIP	PHONE
HEALTH CARE PROFESSIONAL COMPLETING FORM	ROLE / CREDENTIALS	PHONE

Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition) ☐ **Check here if not discussed**

This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.
Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult with the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.

Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.

☐ Preference is to avoid medically assisted nutrition.
☐ Preference is to discuss medically assisted nutrition options, as indicated.*
Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).

* Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.

Discussed with: ____ Individual ____ Health Care Professional ____ Legal Medical Decision Maker

Directions for Health Care Professionals

NOTE: An individual with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

Any incomplete section of POLST implies full treatment for that section. This POLST is valid in all care settings. It is primarily intended for out of hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

Completing POLST
- Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.
- Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual's preferences and medical condition.
- POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. Multiple decision maker signatures are allowed, but not required.
- Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST.
- POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) sign the form along with the health care professionals. See FAQ at www.wsma.org/POLST.

NOTE: This form is not adequate to designate someone as a health care agent. A separate DPOA-HC is required to designate a health care agent.

Honoring POLST
Everyone shall be treated with dignity and respect.
SECTIONS A AND B:
- No defibrillator should be used on an individual who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.
- Treatment of dehydration is a measure which may prolong life. An individual who desires IV fluids should indicate "Selective" or "Full Treatment."

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

To void this form, draw a line across the page and write "VOID" in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.

Review of this POLST form: Use this section to update and confirm order and preferences.
This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

REVIEW DATE	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME ☐ No Change ☐ Form Voided ☐ New Form Completed

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Review of Patient Care & Treatment

Determining resuscitation status

- Look for a Valid POLST form, or other healthcare resuscitation order form.
    - If in a home setting, look for a POLST form next to the front door, on or in the refrigerator, or look for a Vial of Life.
    - If in an extended or intermediate care facility, look for the resuscitation form in the patient's chart.
- When a form is located, verify it is complete with the patient's information and appropriate signatures.
- Contact medical control for further consultation as needed

Valid resuscitation orders on hand:

POLST:

Provide resuscitation based on the individual's wishes identified on the form.

Provide medical interventions identified on the form.

Always provide comfort care.

Other Resuscitation Orders:

Contact medical direction.

Follow specific orders in the resuscitation order as appropriate to your provider certification level.

Exceptions

Do not initiate resuscitation measures when the patient is determined to be obviously dead:

- Decapitation
- Evisceration of the heart or brain
- Incineration
- Rigor mortis
- Decomposition
- Dependent lividity

If, in your medical judgment, you determine your patient has attempted suicide or is a victim of a homicide, begin resuscitation.

Stopping resuscitative efforts for DNR/DNAR Status

- Once you are aware of a valid DNR/DNAR status, stop the following treatment measures:
  - Basic CPR
  - Intubation
  - Cardiac monitoring and defibrillation
  - Administration of resuscitation medications
  - Any positive pressure ventilation

Revoking the resuscitation order

- The following individuals can inform the EMS system that the DNAR order has been revoked:
  - The patient
  - The patient’s physician
  - The legal medical decision maker for the patient

Next Steps

- Provide comfort care
- Conduct an ongoing assessment as appropriate
- Transport if necessary
- Support grieving family members
- Document, Document, Document
- Always follow local protocol

EMS Provider Mental Health

- Seek help if needed.
- Take time for yourself.
- Breathe.
- Meditate.
- Make your mental health a priority.
- Find healthy coping mechanisms.
- We are not invincible, even if we are superheroes.

Any Questions?

Thank you to Mason County EMS for the assistance with creating this presentation

To request this document in another format, call 1-800-525-0127. Deaf or hard of
hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.