

Do Not Resuscitate, Advance Directives, Physician Orders for Life-Sustaining Treatment & End-Of-Life Decision-Making Process, Clin 08.01

Effective Date: March 05, 2009

POLICY

Note: This policy does not apply to persons who have been declared brain dead (see the policy, "Guidelines for Determination of Brain Death, Clin 08.03").

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1. Introduction

It is consistent with existing standards of care not to attempt cardiopulmonary resuscitation in some clinical situations and to withdraw or withhold life support in others. Attention to patient comfort must always be provided, including appropriate medications, positioning, wound care, and other measures to alleviate pain and suffering (see policy, "Comfort Care Measures for the Adult Dying Patient, Clin 08.16").

2. Definitions

Brain Death: see policy, "Guidelines for Determination of Brain Death, Clin 08.03."

Cardiopulmonary Resuscitation (CPR): The use of any of the following therapies to maintain a patient's life at the time of a cardiac or pulmonary arrest:

- Endotracheal intubation and ventilation
- Other advanced airway device use
- Cardiac massage
- Cardiac defibrillation

Decision-Making Capacity: The capacity to make health care decisions is a legal and ethical concept with the following four related elements:

- i. Ability to understand relevant information;
- ii. Ability to appreciate the current situation and its consequences;
- iii. Ability to process information rationally; and
- iv. Ability to communicate a choice.

Do Not Resuscitate/Do Not Attempt Resuscitation (DNR) (Allow Natural Death): An order not to attempt cardiopulmonary resuscitation. This order would only apply when patients are pulseless and apneic.

HIM: Health Information Management

Integrated Health Record (IHR): the electronic medical record.

Life Support Treatment: Life support treatment may include, but is not limited to, ventilators, dialysis, blood products, medications, implantable defibrillators and pacemakers, tube feedings, hyperalimentation, and intravenous fluids.

Permanently Unconscious: Complete lack of an awareness of self and external environment, with no reasonable possibility of a return to the conscious state, medically confirmed by a neurological specialist with expertise in the examination of unresponsive individuals. This includes a persistent vegetative state, which, for purposes of this document, means a patient who has had irreversible total loss of cortical brain function as documented by a neurological specialist.

Surrogate Decision-Makers: If a patient lacks capacity to provide consent or has been declared by a court or law to be incompetent, the legal guardian or health care representative designated by an Advance Directive may provide the informed consent on behalf of the patient. Those who may provide consent on behalf of a patient who lacks capacity are **(listed in order of authority)**:

1. A legal guardian
2. A surrogate of the patient who is appointed by an Advance Directive to make health care decisions
3. The patient's spouse or registered domestic partner
4. An adult designated by the others listed in this subsection who can be located, so long as no person listed in the subsection objects to the designation
5. A majority of the adult children of the patient who can be located with reasonable effort
6. Either parent of the patient
7. A majority of the adult siblings of the patient who can be located with reasonable effort
8. Any adult relative or adult friend
9. The attending physician in consultation with the Patient Advocate and a member of the nursing staff

Also see the policy, "Consent, Clin 02.08"

Valid Physician Orders for Life Sustaining Treatment (POLST): A POLST form is valid if it includes the patient's name, date of completion, resuscitate or do not resuscitate orders, and is

signed by a physician (MD or DO), nurse practitioner, or physician's assistant (the signer does not need to have clinical privileges at OHSU). Any section that is not completed is assumed to indicate full treatment.

3. Attempt Resuscitation

- A. At the moment of cardiac or pulmonary arrest, patients are not able to express their treatment preferences. Failure to act in this situation will result in the patient having no opportunity for resuscitation, even though providing CPR is not certain to avoid death. Therefore, consent to administer CPR is presumed unless one of the exceptions in Section 4 of this policy is present.
- B. Patients with a valid POLST form, per the above definition, that includes orders for CPR and/or other life-sustaining treatments, must have those orders respected. Alternative orders for administering life-sustaining treatment should be written only if new information becomes available.

4. Do Not Attempt Resuscitation

- A. Patients who have decision-making capacity and who have expressed in advance their preference that CPR be withheld, must have their wishes respected, even when such refusal of care is likely to result in serious injury or death.
- B. A decision to withhold CPR from a patient who lacks decision-making capacity can be made by the surrogate decision-maker (as defined above) based on the previously expressed preferences of the patient or in accordance with the patient's best interests if such preferences are unknown.
- C. Patients with a valid POLST form that includes a DNR (Allow Natural Death) order will have that order followed. Alternative orders for administering life-sustaining treatment should be written only if new information becomes available regarding updated patient/surrogate wishes or an updated document.

5. Limited Additional Interventions

The provision or limitations of additional interventions should be provided as directed in a valid POLST form or as agreed upon by the health care team and the patient or surrogate decision-maker. Such additional interventions include, but are not limited to:

- A. Blood transfusions
- B. Dialysis
- C. Intensive Care Unit admission
- D. Administration of vasopressors
- E. Artificial nutrition/hydration
- F. Administration of antibiotics

6. Withdrawing/Withholding Life Support

- A. Patients with Decision-Making Capacity:** As with the acceptance or refusal of CPR, adequately informed patients who have decision-making capacity have the right to accept or refuse any other life-sustaining treatments. Physicians should discuss other treatment options with the patient.
- B. Patients without Decision-Making Capacity:** If a patient who has not expressed preferences for life-sustaining treatment becomes incapable of expressing those preferences, a decision should be made in consultation with the surrogate decision-

makers. Physicians should discuss other elements of treatment with the surrogate and the other members of the health care team.

- C. Comfort Care Required:** It is the policy of OHSU that every effort should be taken to ensure that the patient is made as comfortable as possible by adequately treating pain and other symptoms and addressing the psychological and spiritual needs of the patient.
- D. Irreversible Coma and Life Support:** see the policy, “Irreversible Coma and Life Support, Clin 08.04.”

7. Standards and Process for Decision and Consent

- A.** Physicians should discuss with appropriate patients the possibility of withholding/withdrawing life support, including CPR. Patients should be encouraged to express in advance their preferences regarding CPR and other life support procedures. These discussions should include a description of any anticipated procedures and their likely outcomes and should ideally occur in an outpatient setting where general treatment preferences are discussed or as early as possible before or during hospitalization. The discussion should include the differences that may occur between DNR activities on the ward versus in the operating room (i.e., treatment of reversible complications of surgery or anesthesia – see Section 13 below). Outpatients who have advanced frailty or advanced chronic illness and who have expressed treatment preferences should be offered the opportunity to have a POLST form that creates medical orders to document their treatment preferences in advance of a crisis situation.
- B.** OHSU Hospitals and Clinics complies with the federal Patient Self Determination Act and ORS 127.005 (et. seq.) by:
 - i. Informing patients of their right to accept or refuse medical treatment;
 - ii. Asking patients if they have completed an Advance Directive (Directive to Physicians, “Living Will,” Healthcare Proxy, or Power of Attorney for Health Care)
 - iii. Providing adult patients who have not completed an Advance Directive with a copy of the document during the admission process; and
 - iv. Assuring that a copy of any Advance Directive information or POLST form is faxed to Health Information Management (HIM) to be scanned into the patient’s IHR.
 - v. If a patient lacks the capacity to make a decision regarding the use of life support procedures, including CPR, a decision may be made by a surrogate or decision-maker based on the previously expressed preferences of the patient or, if such preferences are unknown, in accordance with the patient’s best interests. Unless otherwise designated by law, parents are the legal guardians for children under the age of 18. The first of the individuals defined above as surrogate decision-makers who can be located upon reasonable effort and who is willing to serve may consent to the withdrawal or withholding of life support treatment when the patient is in one of the conditions described in the following section.
 - vi. The physician has a legal and ethical obligation to honor the preferences expressed by the patient or the patient’s surrogate when the patient is in one of the following conditions:
 - A terminal condition
 - Permanent unconsciousness
 - A state in which life support treatment would not benefit the patient’s medical condition and would cause permanent and severe pain

- A state of advanced, progressive, terminal illness in which the patient is permanently unable to communicate by any means, swallow food or water safely, care for him/herself, recognize familiar persons, and is very unlikely to substantially improve.
- v. For all other conditions, when the patient lacks capacity the physician must consider the preferences expressed by other surrogates.
- vi. When there is disagreement among concerned parties, an attempt should be made to assure an impartial and sensitive review of the options with involvement of the Patient Advocate. If disagreement cannot be resolved at the Unit level, a clinical ethics consultation and/or consultation by a second physician not directly involved in the patient's care should be obtained. Unless there are orders to the contrary, life-sustaining treatment should be continued during this period.
- vii. Physicians, nurses and other members of the health care team are not permitted to place their personal values ahead of the patient's or surrogate's preferences. Health care professionals have the right to have patient care assumed by others and not participate in the withholding or withdrawal of life sustaining treatments. (see the policy, Conscientious Objection, Adm 07.05). Health care professionals may not use the Conscientious Objection policy as a way to refuse to honor a patient or surrogate's preferences to request CPR or request continuation of other life-sustaining treatments. However, health care professionals are not required to provide futile care.

8. Identification and Documentation for Outpatients

- A.** A note should be entered into the patient's IHR stating the reasons that CPR or other life support treatments will not be performed and documenting discussions with the patient or surrogate. The nature of the patient's or surrogate's decision should be stated. In the outpatient setting all adults who express an interest should be offered the opportunity to complete an Advance Directive. Patients with advanced frailty or limited life expectancies should be offered the opportunity to record more specific medical orders documenting goals of treatment on a POLST form. If the patient's health status changes it is appropriate to revisit and/or void the orders on the POLST form, and complete another POLST form if the goals of care and/or the patient's wishes have changed.
- B.** An order to withhold or withdraw life support, including a DNR order, should be written on a POLST form documenting the patient's wishes. The original POLST form should be given to the patient and a copy of the POLST form must be faxed to HIM to be scanned into the patient's IHR.
- C.** The following elements are required for a valid POLST form:
 - i. All identifying information must be completed in the upper right box
 - ii. Section A must be completed (marking a box to indicate CPR or DNR)
 - iii. A physician, nurse practitioner or physician's assistant must sign and date the form; and
 - iv. Sections B, C, and D should be completed if possible but may be left blank if decisions have not been made about these medical treatments (the default for any sections left blank is full treatment).

9. Identification and Documentation for Inpatients

- A. Patients who arrive at the hospital with a completed POLST form or Advance Directive:** When a patient is admitted with an original POLST form, the form must be faxed to HIM to be scanned into the IHR and the original document placed in the red plastic sleeve of the travel folder. The health care professional will review the POLST orders and verify wishes with the patient. The health care professional will then write admission orders in accordance with the patient's current wishes. If the patient's condition makes verification impossible, the orders on the POLST form will be followed until or unless information to the contrary becomes available.
- B. For scheduled admissions:** Admitting personnel must inquire about Advance Directives as required by law and prepare a travel folder. For those who already have an Advance Directive or POLST form in the IHR, the most recent copy of each of these documents (determined by the most recent date signed) must be printed and placed in a red, clear plastic sleeve and placed in the travel folder.
- C. For patients admitted via the Emergency Department:** A copy of the current Advance Directive and POLST documents in the IHR will be printed and placed in the red plastic sleeve in the travel folder by the nurse responsible for admitting the patient. The nurse will report the existence of the POLST form in the travel folder to the inpatient nurse accepting the patient. If the patient arrives with a new Advance Directive and/or POLST form, these documents will be faxed to HIM and the original placed in the red plastic sleeve in the travel folder. POLST forms in the travel folder provide access to important information regarding code status for potential use when the patient is in transit and admission orders including code orders have not yet been written.
- D. For patients admitted from the outpatient setting:** A copy of the current Advance Directive and POLST documents in the IHR will be printed and placed in a red plastic sleeve by the medical assistant who is providing a report to the inpatient nurse accepting the patient.

10. Writing Code Orders for Inpatients

- A.** An order regarding code status is required on every patient admitted to the hospital.
- B.** A fully informed discussion must occur with the patient or surrogate before documenting a code status, whether full code or DNR/DNI.
- C.** The physician will consult the red plastic sleeve in the travel folder (if available) which contains the Advanced Directive and/or POLST form before placing an order regarding code status.
- D.** When a patient is changing level of service (e.g., ICU to ward status) the physician should have full appreciation of any previous discussions held with the patient regarding code status before initiating conversations with the patient or placing an order.
- E.** Attending physicians are required to complete a code status order if not completed by the admitting team within 24 hours of the patient's admission.

11. Voiding POLST Forms and Changing Code Status

- A.** A patient arriving with a POLST form that has been signed by a physician, nurse practitioner or physician assistant will have those orders respected and subsequently reflected in admitting orders unless otherwise rescinded or modified.
- B.** The patient may rescind a POLST form or Advance Directive and the patient and surrogate can request a change in code status. For outpatients and inpatients, code status and POLST forms should be re-evaluated and revised if needed each time there

is a substantive change in the patient's condition. Whenever there is a change in code status the red clear plastic travel folder must be updated by printing a copy of the new order and removing the old order. A single diagonal line and the word **VOID** in large letters should be written across any outdated POLST form and the form should be removed from the travel folder and faxed to HIM for scanning.

- C. When new orders regarding code status are entered into the IHR, a copy of these orders should immediately be placed in the travel folder. Likewise, any new POLST form or Advance Directive must be faxed to HIM and then placed in the red sleeve of the travel folder (original POLST forms will be sent with the patient at discharge).

12. Status of POLST Form on Discharge

- A. When a hospitalized patient has a DNR order or other orders to limit life-sustaining treatment and wishes those orders to continue after discharge, then those wishes should be recorded on a POLST form as signed medical orders. Prior to discharge to either another facility (e.g., long term care, hospice, or another hospital), a POLST form should be completed in accordance with the patient's current wishes unless declined by the patient or surrogate.
- B. If a patient's wishes have not changed and s/he arrived with an original POLST form, then the POLST form should be returned to the patient at discharge after assuring that a copy of this document has been scanned into the IHR and faxed to HIM at discharge if the POLST form has not been previously scanned. The original form should be returned to the patient or surrogate at discharge.
- C. When a POLST form is newly created for a patient being discharged, the original goes with the patient and a copy is faxed to HIM at discharge to be scanned into the IHR.
- D. If a patient arrives with a POLST form and the goals of care have changed, the POLST form should be revised and faxed to HIM and the copy in the travel folder voided and faxed to HIM.
- E. DNR orders in the IHR and on a POLST form must be dated and the order with the most recent date is the current order and has standing. Because POLST forms have more information than just code status, they complement orders regarding CPR use as does an Advance Directive that provides information about values in a future health state and appointment of a surrogate. Accordingly, the red clear plastic sleeve in the travel folder might contain all three documents: Advance Directive, a POLST form, and a DNR or DNR/DNI orders from the current hospitalization. The only reason to void and remove documents from the red plastic sleeve is because they are no longer valid (e.g., code status has changed).

13. Honoring DNR Orders in the Operating Room

Unique circumstances exist when a patient with a DNR order consents to a surgical procedure. Once the patient consents to the surgical procedure, the DNR order is rescinded for the duration of the procedure. A DNR order must be rewritten before the patient leaves the recovery room.

14. Roles and Responsibilities in obtaining, documenting and retaining Advance Directives and POLST forms

Responsibility	Actions
Patient Access Services (PAS) Representative	<ol style="list-style-type: none"> 1. Review the patient's IHR for presence of Advance Directive or POLST document. Confirm accuracy of existing documents or clarify patient's wishes regarding the documents. 2. For patients who have not completed an Advance Directive, offer a copy of the Oregon Health Decision booklet, "Making Health Decisions When You Can't Speak for Yourself." If the patient is not able to receive this information upon admission, follow up until the patient receives the information, up to and including date of discharge. 3. If the patient has completed an Advance Directive or has a POLST form, request a copy of the form(s) for the IHR. 4. Place copy of the POLST form (including original pink form) and/or Advance Directive in the red plastic sleeve of the travel folder. 5. Fax any new Advance Directive and/or POLST form to Health Information Management (HIM) to be scanned into the IHR.
Nursing Staff	<ol style="list-style-type: none"> 1. If Advance Directive or POLST form exists but is not available, ask the family to produce the patient's documentation. Copy the documentation, return the original to the patient or family, fax the copy to HIM and file the copy in the red folder. 2. If the patient signs an Advance Directive or completes a POLST form <u>after admission</u>, follow steps in Section 12C above.
Health Information Management (HIM)	<ol style="list-style-type: none"> 1. Update Advance Directives and POLST fields in the IHR. 2. If old POLST or Advance Directive documents (based on date signed) already exist in the IHR: <ol style="list-style-type: none"> a. Print the old document(s); b. Write "VOID" diagonally across the document; c. Scan the voided document in the IHR; and d. Delete the original old document. <p>Only the new, current POLST form and/or Advance Directive should be in the IHR without the word "VOID" across the document. The date of the document is set as the date signed, not the date scanned.</p> 3. Assure that yes/no for the POLST form and Advance Directive on header in the outpatient IHR is corrected to reflect the addition of new documents to the IHR. Documents should be scanned and viewable in the IHR

Responsibility	Actions
	within 24 hours of receipt by HIM.
PAS Representatives, Nurses, Physicians, Other Health Care Team Members	<p>For patients who wish additional information or assistance in completing forms on:</p> <p>Weekdays, 8:00 AM - 4:30 PM: Call the Care Management Department. The Social Worker assigned to the inpatient unit will be contacted to assist the patient. If the Social Worker is not available, the Patient Advocate or Director of Shift Operations will be contacted to assist the patient.</p> <p>Evenings, nights, weekends and holidays: Call the Operator and have the Director of Shift Operations paged.</p>
All Health Care Team Members	<ol style="list-style-type: none"> 1. Advance Directives and POLST forms are visible in the IHR in the Chart Review Media Tab. 2. In the Emergency Department and Ambulatory Clinics, the Advance Directive or POLST form is visible in the patient header or in the Snapshot. 3. Staff will be educated about changes or any additional areas of visibility in the record. 4. If a patient is being transferred to a receiving facility or intermediate care facility: <ol style="list-style-type: none"> a. Make a copy of the Advance Directive or POLST form. b. If the patient has an original POLST form in the travel folder, return the original pink document to the patient after the copy has been entered into the IHR. If it has not been entered into the IHR, fax the form to HIM. 5. Include the forms with other transfer papers to be sent to the skilled nursing facility or intermediate care facility.
Medical Interpreter Services	Maintain translated & English versions of Advance Directives or POLST forms on the O-Zone Index of Translated Patient Education Handouts .

Bibliography:

- [Oregon Revised Statutes \(ORS\) - Chapter 127](#): Powers of Attorney; Advance Directives for Health Care; Declarations for Mental Health Treatment; Death with Dignity
- [Physician Orders for Life-Sustaining Treatment Paradigm](#)

Related Forms and Procedures:

- [Guidelines for Determination of Brain Death, Clin 08.03](#)
- [Comfort Care Measures for the Adult Dying Patient, Clin 08.16](#)
- [Consent, Clin 02.08](#)
- [Irreversible Coma and Life Support, Clin 08.04](#)
- [Conscientious Objection, Adm 07.05](#)
- [O-Zone Index of Translated Patient Education Handouts](#)

Education/Training Resources:

- [Advance Directive & POLST Form Management \(Power Point tool\)](#)

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