Islands Hospice

The Basics of Advance Care Planning

Presented by
Iris Hashimoto, LCSW
Ednalyn Diaz, LSW

Topics Covered

- Basic Terminology
- Important Documents

Basic Terminology

- Advance Care Planning
  - The process of discussing the type of care you would or would not want for yourself.
  - Preferences such as the type of care you want, where you would want to pass away, who would make decisions for you.
  - Creates a written record of your wishes, values, preferences, and decisions to ensure that care is delivered in the way you desire.

Basic Terminology

- Advance Directives
  - Directives that pertain to treatment preferences and the designation of a surrogate decision maker when you are no longer able to make decisions on your own behalf.
  - There are 3 categories of Advance Directives…

Basic Terminology

- 3 Categories of Advance Directives continued…
- 1. Living Will
  - A written document intended to specify your medical wishes for when you are still living.
  - Living will can be very specific or general.
  - Includes decisions regarding prolonging life or withdrawing treatment; artificial nutrition and hydration as well as use of pain medication.

Basic Terminology

- 3 Categories of Advance Directives continued…

- 2. Healthcare Proxy (Power of Attorney)
  - This person is designated to make health care decisions on your behalf.
  - This person knows what you want.

Basic Terminology

- 3 Categories of Advance Directives continued…

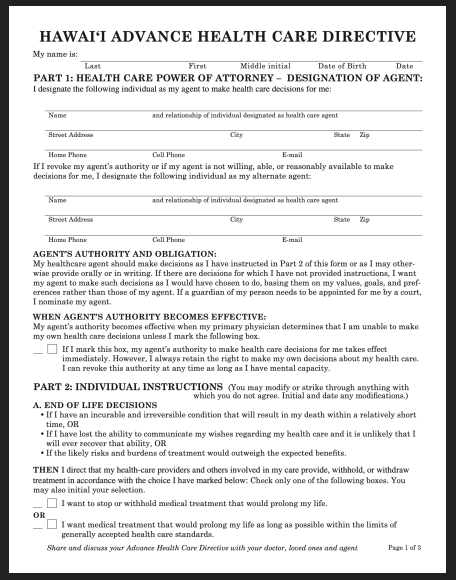
- 3. Durable Power of Attorney
  - A person who is designated to make healthcare and financial decisions on your behalf if you become incapacitated.

Important Documents

- Advance Health Care Directive
- POLST

Advance Healthcare Directive

- Advance Health Care Directive
  - Everyone over 18 should have one.



HAWAI'I ADVANCE HEALTH CARE DIRECTIVE

My name is: _____ _____ _____ _____ _____
Last First Middle initial Date of Birth Date

PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:
I designate the following individual as my agent to make health care decisions for me:

_____
Name and relationship of individual designated as health care agent

_____ _____ _____
Street Address City State Zip

_____ _____ _____
Home Phone Cell Phone E-mail

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

_____
Name and relationship of individual designated as health care agent

_____ _____ _____
Street Address City State Zip

_____ _____ _____
Home Phone Cell Phone E-mail

AGENT'S AUTHORITY AND OBLIGATION:
My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:
My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

__ ☐ If I mark this box, my agent's authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care. I can revoke this authority at any time as long as I have mental capacity.

PART 2: INDIVIDUAL INSTRUCTIONS (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

A. END OF LIFE DECISIONS
- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.

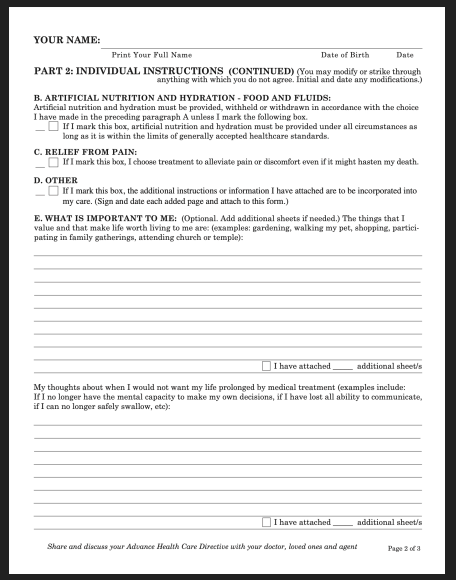
THEN I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: Check only one of the following boxes. You may also initial your selection.

__ ☐ I want to stop or withhold medical treatment that would prolong my life.

OR

__ ☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent Page 1 of 3



YOUR NAME: _____
Print Your Full Name Date of Birth Date

PART 2: INDIVIDUAL INSTRUCTIONS (CONTINUED) (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:
Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

__ ☐ If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

C. RELIEF FROM PAIN:

__ ☐ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. OTHER

__ ☐ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

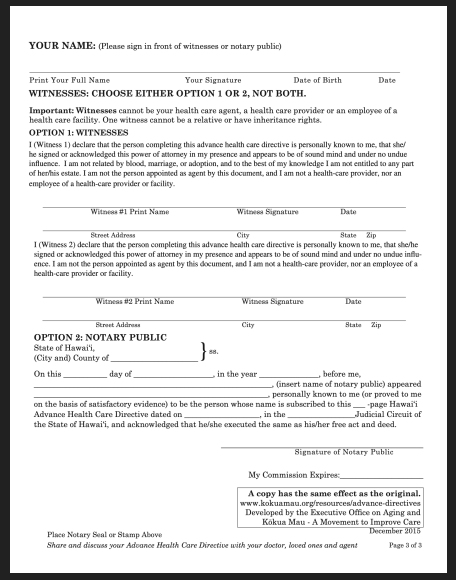
E. WHAT IS IMPORTANT TO ME: (Optional. Add additional sheets if needed.) The things that I value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple):

_____
☐ I have attached _____ additional sheet/s

My thoughts about when I would not want my life prolonged by medical treatment (examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

_____
☐ I have attached _____ additional sheet/s

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent Page 2 of 3



YOUR NAME: (Please sign in front of witnesses or notary public)

_____ _____ _____ _____
Print Your Full Name Your Signature Date of Birth Date

WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.

Important: Witnesses cannot be your health care agent, a health care provider or an employee of a health care facility. One witness cannot be a relative or have inheritance rights.

OPTION 1: WITNESSES

I (Witness 1) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not related by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of her/his estate. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

_____ _____ _____
Witness #1 Print Name Witness Signature Date

_____ _____ _____ _____
Street Address City State Zip

I (Witness 2) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

_____ _____ _____
Witness #2 Print Name Witness Signature Date

_____ _____ _____ _____
Street Address City State Zip

OPTION 2: NOTARY PUBLIC

State of Hawai'i,
(City and) County of _____ } ss.

On this _____ day of _____, in the year _____, before me,
_____, (insert name of notary public) appeared
_____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this ___ -page Hawai'i Advance Health Care Directive dated on _____, in the _____Judicial Circuit of the State of Hawai'i, and acknowledged that he/she executed the same as his/her free act and deed.

_____
Signature of Notary Public

My Commission Expires:_____

A copy has the same effect as the original.
www.kokuamau.org/resources/advance-directives
Developed by the Executive Office on Aging and
Kōkua Mau - A Movement to Improve Care
December 2015

Place Notary Seal or Stamp Above

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent Page 3 of 3

HAWAI'I ADVANCE HEALTH CARE DIRECTIVE

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Last First Middle initial Date of Birth Date

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Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

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Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

AGENT'S AUTHORITY AND OBLIGATION:

My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

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THEN I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: Check only one of the following boxes. You may also initial your selection.

__ ☐ I want to stop or withhold medical treatment that would prolong my life.

OR

__ ☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent

Advance Healthcare Directive

- Part 1
  - Designation of Agent

HAWAI'I ADVANCE HEALTH CARE DIRECTIVE

My name is: _____

Last First Middle initial Date of Birth Date

PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

Name and relationship of individual designated as health care agent

Street Address City State Zip

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__ ☐ I want to stop or withhold medical treatment that would prolong my life.

OR

__ ☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

Advance Healthcare Directive

- Part 2
- Individual Instructions

YOUR NAME: _____

Print Your Full Name Date of Birth Date

PART 2: INDIVIDUAL INSTRUCTIONS (CONTINUED) (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:
Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

__ ☐ If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

C. RELIEF FROM PAIN:

__ ☐ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. OTHER

__ ☐ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

E. WHAT IS IMPORTANT TO ME: (Optional. Add additional sheets if needed.) The things that I value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple):

☐ I have attached _____ additional sheet/s

My thoughts about when I would not want my life prolonged by medical treatment (examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

☐ I have attached _____ additional sheet/s

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent

Advance Healthcare Directive

- Part 2
  - Individual Instructions continued…

Advance Healthcare Directive

- Signatures

YOUR NAME: (Please sign in front of witnesses or notary public)

Print Your Full Name | Your Signature | Date of Birth | Date

WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.

Important: Witnesses cannot be your health care agent, a health care provider or an employee of a health care facility. One witness cannot be a relative or have inheritance rights.

OPTION 1: WITNESSES

I (Witness 1) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not related by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of her/his estate. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

Witness #1 Print Name | Witness Signature | Date

Street Address | City | State | Zip

I (Witness 2) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

Witness #2 Print Name | Witness Signature | Date

Street Address | City | State | Zip

OPTION 2: NOTARY PUBLIC

State of Hawai'i,
(City and) County of _____ } ss.

On this _____ day of _____, in the year _____, before me, _____, (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this ___ -page Hawai'i Advance Health Care Directive dated on _____, in the _____Judicial Circuit of the State of Hawai'i, and acknowledged that he/she executed the same as his/her free act and deed.

Signature of Notary Public

My Commission Expires:_____

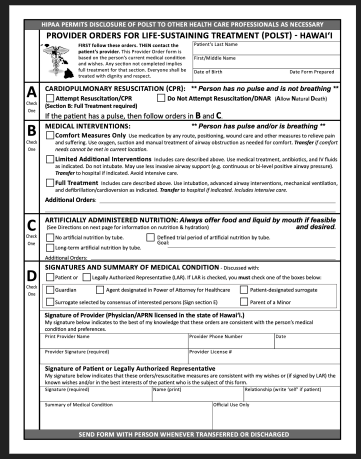
A copy has the same effect as the original.
www.kokuamau.org/resources/advance-directives
Developed by the Executive Office on Aging and Kōkua Mau - A Movement to Improve Care
December 2015

Place Notary Seal or Stamp Above

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent

POLST

- POLST
  - Provider Order for Life Sustaining Treatment
  - A medical order, signed by a medical professional.
  - Should be completed when a person is seriously ill or has advanced frailty.


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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAI'I

FIRST follow these orders, THEN contact the patient's provider. This Provider Order form is based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name | First/Middle Name | Date of Birth | Date Form Prepared

A — CARDIOPULMONARY RESUSCITATION (CPR): ** Person has no pulse and is not breathing **
☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNAR (Allow Natural Death)
(Section B: Full Treatment required)
If the patient has a pulse, then follow orders in B and C

B — MEDICAL INTERVENTIONS: ** Person has pulse and/or is breathing **
☐ Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer if comfort needs cannot be met in current location.
☐ Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). Transfer to hospital if indicated. Avoid intensive care.
☐ Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.
Additional Orders:

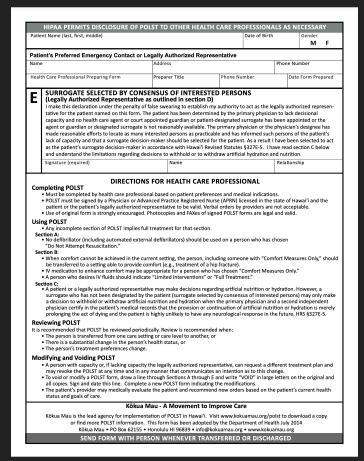
C — ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquid by mouth if feasible and desired.
(See Directions on next page for information on nutrition & hydration)
☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. Goal:
☐ Long-term artificial nutrition by tube.
Additional Orders:

D — SIGNATURES AND SUMMARY OF MEDICAL CONDITION Discussed with:
☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below:
☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate
☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.
Print Provider Name | Provider Phone Number | Date
Provider Signature (required) | Provider License #

Signature of Patient or Legally Authorized Representative
My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.
Signature (required) | Name (print) | Relationship (write "self" if patient)
Summary of Medical Condition | Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED


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

Patient Name (last, first, middle) | Date of Birth | Gender M F

Patient's Preferred Emergency Contact or Legally Authorized Representative
Name | Address | Phone Number
Health Care Professional Preparing Form | Preparer Title | Phone Number | Date Form Prepared

E — SURROGATE SELECTED BY CONSENSUS OF INTERESTED PERSONS (Legally Authorized Representative as outlined in section D)
I make this declaration under the penalty of false swearing to establish my authority to act as the legally authorized representative for the patient named on this form. The patient has been determined by the primary physician to lack decisional capacity and no health care agent or court appointed guardian or patient-designated surrogate has been appointed or the agent or guardian or designated surrogate is not reasonably available. The primary physician or the physician's designee has made reasonable efforts to locate as many interested persons as practicable and has informed such persons of the patient's lack of capacity and that a surrogate decision-maker should be selected for the patient. As a result I have been selected to act as the patient's surrogate decision-maker in accordance with Hawai'i Revised Statutes §327E-5. I have read section C below and understand the limitations regarding decisions to withhold or to withdraw artificial hydration and nutrition.
Signature (required) | Name | Relationship

DIRECTIONS FOR HEALTH CARE PROFESSIONAL

Completing POLST
- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a Physician or Advanced Practice Registered Nurse (APRN) licensed in the state of Hawai'i and the patient or the patient's legally authorized representative to be valid. Verbal orders by providers are not acceptable.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST
- Any incomplete section of POLST implies full treatment for that section.

Section A:
- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Section C:
- A patient or a legally authorized representative may make decisions regarding artificial nutrition or hydration. However, a surrogate who has not been designated by the patient (surrogate selected by consensus of interested persons) may only make a decision to withhold or withdraw artificial nutrition and hydration when the primary physician and a second independent physician have both documented in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future. HRS §327E-5.

Reviewing POLST
It is recommended that POLST be reviewed periodically. Review is recommended when:
- A person with capacity or (if lacking capacity the legally authorized representative, can request a different treatment plan and all copies. Sign and date this line. Complete a new POLST form indicating the modification.
- The person's treatment preferences change.

Modifying and Voiding POLST
- A person with capacity or (if lacking capacity the legally authorized representative, can request a different treatment plan and all copies. Sign and date this line. Complete a new POLST form indicating the modification.
- To void or modify a POLST form, draw a line through Sections A through E and write "VOID" in large letters on the original and all copies. Sign and date this line. Complete a new POLST form indicating the modification.
- The patient's provider may medically evaluate the patient and recommend new orders based on the patient's current health status and goals of care.

Kōkua Mau - A Movement to Improve Care
Kōkua Mau is the lead agency for implementation of POLST in Hawai'i. Visit www.kokuamau.org/polst to download a copy or find more POLST information. This form has been adopted by the Department of Health July 2014
Kōkua Mau • PO Box 62105 • Honolulu HI 96839 • info@kokuamau.org • www.kokuamau.org

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAI'I

FIRST follow these orders. THEN contact the patient's provider. This Provider Order form is based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name	
First/Middle Name	
Date of Birth	Date Form Prepared

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): ** *Person has no pulse and is not breathing* **

☐ **Attempt Resuscitation/CPR** (Section B: Full Treatment required)

☐ **Do Not Attempt Resuscitation/DNAR** (Allow Natural Death)

If the patient has a pulse, then follow orders in **B** and **C**.

B Check One

MEDICAL INTERVENTIONS: ** *Person has pulse and/or is breathing* **

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). ***Transfer*** to hospital if indicated. Avoid intensive care.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Always offer food and liquid by mouth if feasible and desired.***

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube. Goal: _____

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D Check One

SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:

☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate

☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)

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

Print Provider Name	Provider Phone Number	Date
Provider Signature (required)	Provider License #	

Signature of Patient or Legally Authorized Representative

My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

Signature (required)	Name (print)	Relationship (write 'self' if patient)

Summary of Medical Condition	Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

POLST

- Section A:
  - What to do if a person has no pulse and is not breathing

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAI'I

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☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). ***Transfer*** to hospital if indicated. Avoid intensive care.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Always offer food and liquid by mouth if feasible and desired.***

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube. Goal: _____

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D Check One

SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:

☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate

☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)

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

Print Provider Name	Provider Phone Number	Date
Provider Signature (required)	Provider License #	

Signature of Patient or Legally Authorized Representative

My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

Signature (required)	Name (print)	Relationship (write 'self' if patient)

Summary of Medical Condition	Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

POLST

- Section B:
  - What to do if a person has a pulse and is breathing.

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAI'I

FIRST follow these orders. THEN contact the patient's provider. This Provider Order form is based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name	
First/Middle Name	
Date of Birth	Date Form Prepared

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): ** *Person has no pulse and is not breathing* **

☐ **Attempt Resuscitation/CPR** (Section B: Full Treatment required)

☐ **Do Not Attempt Resuscitation/DNAR** (Allow Natural Death)

If the patient has a pulse, then follow orders in **B** and **C**.

B Check One

MEDICAL INTERVENTIONS: ** *Person has pulse and/or is breathing* **

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). ***Transfer*** to hospital if indicated. Avoid intensive care.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Always offer food and liquid by mouth if feasible and desired.***

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube. Goal: _____

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D Check One

SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:

☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate

☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)

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

Print Provider Name	Provider Phone Number	Date
Provider Signature (required)	Provider License #	

Signature of Patient or Legally Authorized Representative

My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

Signature (required)	Name (print)	Relationship (write 'self' if patient)

Summary of Medical Condition	Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

POLST

- Section C:
  - Artificially administered nutrition

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAI'I

FIRST follow these orders. THEN contact the patient's provider. This Provider Order form is based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name

First/Middle Name

Date of Birth | Date Form Prepared

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): ** *Person has no pulse and is not breathing* **

☐ **Attempt Resuscitation/CPR** (Section B: Full Treatment required)

☐ **Do Not Attempt Resuscitation/DNAR** (Allow Natural Death)

If the patient has a pulse, then follow orders in **B** and **C**.

B Check One

MEDICAL INTERVENTIONS: ** *Person has pulse and/or is breathing* **

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). ***Transfer*** to hospital if indicated. Avoid intensive care.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Always offer food and liquid by mouth if feasible and desired.***

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube. Goal: _____

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D Check One

SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:

☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate

☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)

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

Print Provider Name	Provider Phone Number	Date
Provider Signature (required)	Provider License #	

Signature of Patient or Legally Authorized Representative

My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

Signature (required)	Name (print)	Relationship (write 'self' if patient)

Summary of Medical Condition	Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

POLST

- Section D:
  - Signatures and Summary of Medical Condition
  - Patient
  - Guardian
  - Agent designated as POA
  - Patient designated surrogate
  - Surrogate selected by consensus of interested persons.

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

Patient Name (last, first, middle)	Date of Birth	Gender M F

Patient's Preferred Emergency Contact or Legally Authorized Representative

Name	Address	Phone Number

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Form Prepared

E **SURROGATE SELECTED BY CONSENSUS OF INTERESTED PERSONS**
(Legally Authorized Representative as outlined in section D)

I make this declaration under the penalty of false swearing to establish my authority to act as the legally authorized representative for the patient named on this form. The patient has been determined by the primary physician to lack decisional capacity and no health care agent or court appointed guardian or patient-designated surrogate has been appointed or the agent or guardian or designated surrogate is not reasonably available. The primary physician or the physician's designee has made reasonable efforts to locate as many interested persons as practicable and has informed such persons of the patient's lack of capacity and that a surrogate decision-maker should be selected for the patient. As a result I have been selected to act as the patient's surrogate decision-maker in accordance with Hawai'i Revised Statutes §327E-5. I have read section C below and understand the limitations regarding decisions to withhold or to withdraw artificial hydration and nutrition.

Signature (required)	Name	Relationship

DIRECTIONS FOR HEALTH CARE PROFESSIONAL

Completing POLST
- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a Physician or Advanced Practice Registered Nurse (APRN) licensed in the state of Hawai'i and the patient or the patient's legally authorized representative to be valid. Verbal orders by providers are not acceptable.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST
- Any incomplete section of POLST implies full treatment for that section.

Section A:
- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Section C:
- A patient or a legally authorized representative may make decisions regarding artficial nutrition or hydration. However, a surrogate who has not been designated by the patient (surrogate selected by consensus of interested persons) may only make a decision to withhold or withdraw artificial nutrition and hydration when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future. HRS §327E-5.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:
- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST
- A person with capacity or, if lacking capacity the legally authorized representative, can request a different treatment plan and may revoke the POLST at any time and in any manner that communicates an intention as to this change.
- To void or modify a POLST form, draw a line through Sections A through E and write "VOID" in large letters on the original and all copies. Sign and date this line. Complete a new POLST form indicating the modifications.
- The patient's provider may medically evaluate the patient and recommend new orders based on the patient's current health status and goals of care.

Kōkua Mau - A Movement to Improve Care

Kōkua Mau is the lead agency for implementation of POLST in Hawai'i. Visit www.kokuamau.org/polst to download a copy or find more POLST information. This form has been adopted by the Department of Health July 2014

Kōkua Mau • PO Box 62155 • Honolulu HI 96839 • info@kokuamau.org • www.kokuamau.org

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

POLST

- Section E:
  - Surrogate selected by consensus of Interested Persons.
  - LAR (Legally Authorized Representative as outlined in Section D.)

Key Takeaways and Discussion

- Everyone needs an Advance Healthcare Directive
- Not Everyone needs a POLST.
- Download and Print blank copies at
  - www.islandshospice.com
- Talk to your doctor
- For additional education, call Islands Hospice and request our Transitional Care Program.
  - 550-2552

Islands Hospice