VOLUME 1: GOVERNANCE AND ADMINISTRATION	Effective Date: 09/2010
CHAPTER 18	Revision Date: 07/2017
1.18.2 PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) PROCEDURE	Attachments: Yes ☐ No ☒

I. PROCEDURE OVERVIEW

Physician Orders for Life Sustaining Treatment (POLST) is a legally recognized mechanism by which patients can provide specific instructions for their end-of-life care, including requests regarding resuscitation. It is appropriate to consider obtaining and/or completion of a POLST for patients that are elderly, frail, have serious medical or surgical conditions, or who have less than six months life expectancy. Key provisions of the CDCR 7465 POLST are as follows:

- The CDCR 7465 POLST is required to be signed by a Primary Care Provider (PCP) and the individual or the individual's surrogate. Health care staff may discuss the form with the patient and help prepare the form, but the POLST must be signed by a PCP.
- Health care providers are required to honor the provisions of the POLST.
- Health care providers have statutory immunity[1] for honoring a POLST form that appears valid.

California Correctional Health Care Services (CCHCS) shall ensure effective communication is achieved and documented when there is an exchange of health care information in accordance with Inmate Medical Services Policies and Procedures, Volume 1, Chapters 28.1 and 28.2, Effective Communication Documentation Policy and Procedure.

II. DEFINITIONS

Advance Directive for Health Care: A written instrument which allows the patient to do *either or both* of the following: 1) state instructions for future health care decisions; and/or 2) appoint an agent with Power of Attorney for Health Care.

Capacity: A person's ability to understand the nature and consequences of a decision and to make and communicate a decision and includes in the case of proposed health care the ability to understand its significant benefits, risks, and alternatives.

Do Not Resuscitate: A written order which directs that resuscitation efforts (i.e., intubation and assisted mechanical ventilation, cardiac compression, defibrillation, and administration of cardiotonic drugs) are not to be initiated in the event of cardiac and/or respiratory arrest.

Legally Recognized Decision-Maker: Includes an agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, court-appointed conservator or guardian, or person whom the patient's physician/nurse practitioner/physician assistant believes best knows what is in the patient's

[1] Provides statutory immunity from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction to a healthcare provider who relies in good faith on the request and honors it.

best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.

Power of Attorney for Health Care: A written instrument designating an agent to make health care decisions for the principal.

Primary Care Provider: A physician, nurse practitioner, or physician assistant designated to have primary responsibility for the patient's health care or, in the absence of a designation or if the designated physician is not reasonably available or declines to act as primary physician, a physician who undertakes the responsibility.

Principal: An adult who executes a power of attorney for health care.

Reasonably Available: Readily available to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health care needs.

III. RESPONSIBILITY

The Chief Executive Officer or designee of each institution is responsible for the implementation, monitoring, and evaluation of this procedure.

IV. PROCEDURE

A. Completing the CDCR 7465

1. CCHCS encourages staff to promote a patient's use of the CDCR 7465 whenever appropriate.
2. Health care staff has professional obligations to discuss end of life decision-making and goals of care, as well as patients' right to name a legally recognized decision-maker and to specify their end of life preferences. This discussion should occur at clinically appropriate times with patients who are elderly, frail, have serious medical or surgical conditions, or who have less than six months life expectancy. The PCP is responsible for using language and communication methods that are appropriate and effective for the specific patient. It is often a good practice for PCPs to engage their patients in end of life preference discussions as soon as patients meet the criteria.
3. PCPs shall document all discussions with a patient regarding the CDCR 7465 in the health record.
4. The PCP shall be responsible for determining whether a patient has the capacity to make medical decisions. The PCP shall request a psychiatric consultation or obtain the assistance of the Chief Medical Executive (CME) or designee when there is a question concerning a patient's capacity to make medical decisions. Determination of diminished capacity shall be documented in the health record. If a patient lacks medical decision-making capacity, their legally recognized decision-maker shall make the decision on behalf of the patient.
5. The PCP shall seek the concurrence and consent of the legally recognized decision-maker before completing a CDCR 7465. In the event the patient is unable to communicate informed health care decisions or lacks the capacity to make health care decisions and has not designated a legally recognized decision-maker either orally or via a written Advance Directive for Health Care, the PCP, CME or designee, and Regional Health Care Executive shall work with the CCHCS Office of Legal Affairs to identify appropriate steps to obtain legal authority for appointment of a legally recognized decision-maker.

B. Distribution and Filing

1. Blank CDCR 7465 forms shall be available in all health care settings.
2. The current original unrevoked POLST is scanned to POLST document in the electronic health records. **The CDCR 7465 is double-sided and both sides shall be scanned.**
3. Any revoked POLST original or copy shall be lined out and marked "revoked-void" and scanned to POLST document type and noted in the Banner Bar of the electronic health record.
4. A copy of the CDCR 7465 shall accompany the patient when transported to the hospital and when transferred to other health care facilities.

C. Conflict Resolution and Special Situations

1. In the event a patient requests medical treatment contrary to generally accepted medical standards, or if the requested medical care would be medically ineffective, or for reasons of conscience, the health care provider or institution (for institutions there must be a pre-existing institutional policy) may decline to comply with the preferences of the patient or the patient's legally recognized decision-maker. In such cases, the PCP shall discuss the case with institution and regional medical leadership and when appropriate, present the case to the CCHCS Ethics Committee for review and consultation.
2. If the patient requests "Do Not Attempt Resuscitation/Do Not Resuscitate (DNR)" status on Section A of the CDCR 7465 it is understood that every effort shall be made to relieve the patient's suffering and maintain comfort. Specifically, **a "Do Not Attempt Resuscitation/DNR" order does not imply that other therapeutic measures necessary to promote comfort will be withheld** (e.g., palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions).
3. Terms such as "slow code" and "chemical code" are inappropriate and shall not be used. In the absence of a CDCR 7465 specifying "Do Not Attempt Resuscitation/DNR," full Cardio Pulmonary Resuscitation shall be initiated for any patient experiencing cardiac and/or respiratory arrest unless otherwise indicated.
4. If there is suspicion that a patient's cardiorespiratory arrest is not a part of a natural or expected death, then resuscitation shall be attempted despite the presence of a CDCR 7465 stating no attempt at resuscitation. This would include a patient suspected of attempted suicide or possibly suffering harm by another.
5. The PCP shall be responsible for discussing with the patient and/or legally recognized decision-maker as appropriate and documenting in the health record whether the POLST/DNR orders are to be maintained or suspended during anesthesia and surgery. This decision shall be communicated to the surgeon prior to the date of the procedure by the PCP. If the surgeon refuses to honor the patient's wishes, a referral to another surgeon willing to do so should be generated by the PCP and the CME or designee should be notified. The surgical team and the patient shall determine in advance of the procedure specifically when the POLST/DNR orders are to be suspended and reinstated.

D. Honoring POLST Orders Completed Outside of the Institution

If a patient with a completed POLST transfers to or from another CDCR institution or outside health care facility, the receiving institution/facility shall accept the sending institution's POLST orders.

E. Documenting the Code Status of a Critically Ill Patient Who Has No POLST or Advance Directive

1. Completion of a CDCR 7465 is not always possible. If DNR status is clinically indicated and in keeping with the patient's wishes, providers may write DNR orders in the absence of a CDCR 7465.
   a. For DNR orders without an accompanying CDCR 7465, a supervising physician not directly involved in the care of the patient shall document his/her concordance in the health record.
   b. A DNR order written without a POLST means only that the patient is not to receive resuscitative measures in the event of a full arrest. Any other limits on medical interventions, such as "do not intubate" or "no blood products," must be specifically ordered.

V. REFERENCES

- California Probate Code, Division 4.7, Part 1, Chapter 1, Sections 4605, 4607, 4609, 4617, 4650, 4654, 4780, 4781, 4781.2, 4781.5, 4782, 4783, 4785, 4734, and 4735
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 9, Article 10, Sections 91100, 91100.1, 91100.4.1, 91100.4.3, 91100.5, 91100.6, 91100.8, 91100.10, and 91100.13
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 1, Chapters 17A and 17B, Advance Directive for Health Care Policy and Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 1, Chapter 20, Health Care Ethics Committee
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 1, Chapters 28.1 and 28.2, Effective Communication Documentation Policy and Procedure
- California Department of Corrections and Rehabilitation 7465, Physician Orders for Life Sustaining Treatment