LaPOST

Louisiana Physician Orders for Scope of Treatment

ADVANCE CARE PLANNING:
A Consumer Handbook

A Participating Program
of National POLST

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Introduction To Advance Care Planning

Advance care planning helps design a treatment strategy or plan as we move through life. The goals of care we have when we are younger may not be the same as when we have a serious, advanced illness. Advance care planning allows health care professionals to understand our goals of care so they match the type of care we receive.

There are documents that allow us to put this information in writing to prevent misunderstandings. The information in these documents needs to be discussed while we are able to participate in the conversation so that our loved ones and care providers understand our wishes/preferences for health care and the personal goals, values, religious or cultural beliefs that affect our decisions.

A description of these documents follows below.

ADVANCE DIRECTIVE

The advance directive, also known as a living will, is a legal document that provides instructions specifying what kind of treatment should be given to us when we are no longer able to make decisions or speak for ourselves. It is restrictive, as it only goes into effect if we have lost the ability to make decisions and are terminally ill. It is usually completed in advance of any known illness. It may be very specific or very vague. Because we complete it ourselves, unless there are other known facts, it must be honored. An advance directive does not need to be notarized, but must be witnessed by two people in order to be valid.

HEALTH CARE POWER OF ATTORNEY

The health care power of attorney authorizes someone else to make decisions for us when we are no longer able to make decisions or speak for ourselves. In Louisiana, there is a specific order of who can make these decisions for us if no written instructions are available. To become valid, the health care power of attorney document must be witnessed by two people.

The personal health care representative is defined in R.S. 40:1159.4 and means a person who has authority in accordance with Louisiana law to act on behalf of an individual who is an adult or emancipated minor in making decisions related to health care because of incapacity.

LOUISIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (LaPOST)

The Louisiana Physician Orders for Scope of Treatment (LaPOST) document is more than an advance directive or a health care power of attorney. It is a physician's order that outlines our wishes for medical treatment and goals of care developed when we have a known serious, advanced illness. It can also be used to translate a living will into a physician's order when we have a life-limiting and irreversible condition.

The LaPOST document must be discussed by us and/or our health care representatives and be appropriately completed. It must be signed by a physician. When it is completed, it must be honored by all health care professionals. It then provides a roadmap for our medical care when we have serious, life-limiting illnesses. The LaPOST document can be completed by our personal health care representatives if we are no longer able to speak for ourselves.

The LaPOST document lists some of the medical treatments we can choose to have or not have. Our doctors and health care teams can help us decide which treatment options will best help us reach the goals we have for our care.

Facts About Advance Care Planning

- We can revoke our advance directives at any time. Others may only change our wishes if there is new knowledge that we would have wanted something else or there is a new treatment which will accomplish our goals of care.
- We should discuss our wishes and goals of care with as many people as we can. Copies of our advance directives and power of attorney for health care should be provided to our doctors, families, neighbors, lawyers and the staff of the facilities where we might live.
- The LaPOST document is honored and respected by religious faiths and cultures, but we can discuss it with our clergy or faith leaders if we are uncertain.
- We can donate organs by signing the back of our driver's licenses, specifying this wish in our advance directives or telling our family/health care representative. For information about organ donation, visit the Louisiana Organ Procurement Agency website at www.lopa.org.

Understanding Medical Treatments And Conditions

It's important for us to understand what each of the following medical treatments and conditions mean, so we should talk to our doctors before we make any decisions. We can then choose which treatment options we want and don't want and which ones meet our goals for care.

TREATMENTS

- **Resuscitation:** Cardiopulmonary resuscitation, or CPR, is an emergency effort to restore breathing and heartbeat, once they have stopped. It may or may not be successful. CPR involves chest compressions designed to provide blood circulation until emergency responders arrive. Emergency care teams may also use a defibrillator, which administers an electric shock to the heart in order to restore a viable heart rhythm, or mechanical ventilation, which involves pumping air into and out of the lungs through a tube. CPR can be beneficial to healthy people who die suddenly, but may not always be helpful for those who are older or who have serious, advanced illnesses. If successful in restoring circulation, CPR may present risks such as a lack of oxygen to the brain resulting in decreased physical or mental ability.
- **DNR:** Do Not Resuscitate (DNR) is a medical order to not try resuscitation because it isn't wanted or because it will not help. DNR is also sometimes called 'Allow Natural Death.' It does not mean 'Do Not Treat.' It always means that comfort will be provided and basic needs met.
- **Comfort Focused Treatments:** These medical treatments are always provided. They are meant to provide comfort and reduce pain and other symptoms. They are not meant to extend life, although some studies have shown that they may.
- **Antibiotics:** Antibiotics are used to fight infections like pneumonia or urinary tract infections, and may reduce the symptoms and pain caused by those infections. They do not usually improve other health conditions which are causing health to decline.
- **Intravenous (IV) Fluids:** These are sterile fluids that are put into the body through a tube placed in a vein in the arm or the neck. IV fluids can be given for short periods of time for a specific illness or reason (goal).
- **Artificial Nutrition/Tube Feeding:** This is a way of providing nutrition through a tube either in the nose or directly through the skin into the stomach. Tube feeding can help people who cannot swallow now, but who are expected to get better. The need for food and fluids will be less as we near the end of life. During this time, our bodies are unable to use food and fluids like a healthy person. When we are near the end of life, we may be more comfortable eating just what we can or want by mouth. Tube feeding may increase risk of pneumonia and may result in swelling and infection. It may not accomplish the goals we want.

CONDITIONS

- **Terminal Condition** is one for which there is no cure available and medical treatment may prolong the dying process. With or without treatment, death will occur in a short period of time.
- **Persistent Vegetative State** is a medical term used to describe a chronic neurological disorder of consciousness characterized by appearing awake at times without awareness. This is relatively rare. Only the brain stem maintains function. Common causes of this are traumatic brain injury, stroke and a lack of oxygen and blood flow after cardiopulmonary arrest.

Health Care Agent (Power of Attorney for Health Care) Information

A Health Care Agent (Power of Attorney for Health Care) is chosen by a person to make health care decisions when that person is unable to make those decisions either due to illness or incapacity. The person given this responsibility may be a spouse, child, other family member or good friend. Louisiana law mandates who is allowed to make decisions in the absence of a designated "health care agent."

These decisions may include (and may be specified on the document):

- *Medical care such as tests, medications and surgery*
- *Stopping or starting treatments according to the person's previously stated instructions or what is in that person's best interest*
- *End-of-life decisions*
- *Interpreting instructions previously discussed*
- *Reviewing and releasing medical records*
- *Placing the person in a health care facility (nursing home or assisted living)*
- *Arranging care for that person*

Financial issues are not usually included in this type of document.

You have been chosen by _____ to be his/her "health care agent." This is an important role and carries with it certain responsibilities.

Prior to accepting this responsibility, the health care agent must be:

- *Willing to take on this role and responsibility*
- *Know the person's wishes and goals of care*
- *Be able to make those decisions even if they are not what the agent would make for themselves or are difficult*
- *Able to make decisions under stressful situations*

If the agent is unable to accept this responsibility, then other arrangements should be made.

Additional Resources

Closure: www.closure.org

Compassion and Support: www.compassionandsupport.org

Caring Connections: www.caringinfo.org

Louisiana Organ Procurement Agency: www.lopa.org

Note: This document provides links to third party websites that are not sponsored, endorsed and/or affiliated in any way with LaPOST and/or the Louisiana Health Care Quality Forum. In providing these third party links, no specific view or belief is endorsed or intended to be endorsed. These links to third party websites are provided as a courtesy and are intended for educational and informational purposes only. The information and content provided through these third party websites does not represent the views or opinions of LaPOST and/or the Louisiana Health Care Quality Forum, and LaPOST and the Louisiana Health Care Quality Forum does not endorse, sponsor or adopt the views, beliefs and/or content expressed through these third party websites.

To learn more about LaPOST, call: 1-225-300-4826 or visit: www.la-post.org.

POWER OF ATTORNEY FOR HEALTH CARE

I, _____ (print full name),being of sound mind, do hereby designate _____ (print full name) as my agent with full power and authority to make health care decisions for me including, but not limited to, a Declaration Concerning Life-Sustaining Procedures in the event I am unable to or choose not to make these decisions for myself. This Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity or other condition that makes an express revocation of my agent impossible or impractical. I also grant my agent the authority to qualify me for all government entitlements including, but not limited to, Medicaid, Medicare, and Supplemental Social Security.

_____ _____

SIGNATURE **PRINT NAME**

_____ _____

CITY, PARISH OF RESIDENCE **STATE OF RESIDENCE**

The declarant has been personally known to me and I believe him or her to be of sound mind.

_____ _____

WITNESS 1 SIGNATURE **WITNESS 1 PRINT NAME**

_____ _____

WITNESS 2 SIGNATURE **WITNESS 2 PRINT NAME**

Notarization of this form is optional.

Sworn and subscribed before me,

this _____day of _____, _____.

_____

Notary Public

#_____

My commission expires _____

STATE OF LOUISIANA
DECLARATION

Declaration made this_____day of_____,_____(month, year).

I,_____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

If at any time I should have an incurable injury, disease or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be a terminal and irreversible condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedure would serve only to prolong artificially the dying process, I direct (initial one only):

_____ That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

_____ That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, Parish, and State of Residence_____

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness_____ Witness_____

"LIVING WILL" DECLARATION

(R.S. 40:1151 et. sec.)

INSTRUCTIONS: Per R.S. 40:1151 et. sec., the Secretary of State's Office has established a registry in which a person, or his attorney, if authorized by the person to do so, may register the original, multiple original, or a certified copy of the declaration. The filing fee is $20.00 to register the Declaration and receive a laminated identification card and ID bracelet. The filing fee for a revocation is $5.00. If a certified copy is requested from this office, there is an additional fee of $10.00. Mail the declaration, with the filing fee, to: Secretary of State, Attn: Publications, P.O. Box 94125, Baton Rouge, LA 70804-9125.

Rev. 02/2016

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

LOUISIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (LaPOST)

FIRST follow these orders, **THEN** contact physician. This is a Physician Order form based on the person's medical condition and preferences. Any section not completed implies full treatment for that section. LaPOST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect. Please see www.La-POST.org for information regarding "what my cultural/religious heritage tells me about end of life care."

LAST NAME _____

FIRST NAME/MIDDLE NAME _____

DATE OF BIRTH **MEDICAL RECORD NUMBER** (optional) _____

PATIENT'S DIAGNOSIS OF LIFE LIMITING DISEASE AND IRREVERSIBLE CONDITION:

_____

_____

GOALS OF CARE:

_____

_____

_____

A. CARDIOPULMONARY RESUSCITATION (CPR): PERSON IS UNRESPONSIVE, PULSELESS AND IS NOT BREATHING

CHECK ONE
- ☐ CPR/Attempt Resuscitation (requires full treatment in section B)
- ☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

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

B. MEDICAL INTERVENTIONS: PERSON HAS PULSE OR IS BREATHING

CHECK ONE
- ☐ FULL TREATMENT (primary goal of prolonging life by all medically effective means) Use treatments in Selective Treatment and Comfort Focused treatment. Use mechanical ventilation, advanced airway interventions and cardioversion if indicated.
- ☐ SELECTIVE TREATMENT (primary goal of treating medical conditions while avoiding burdensome treatments) Use treatments in Comfort Focused treatment. Use medical treatment, including antibiotics and IV fluids as indicated. May use non invasive positive airway pressure (CPAP/BiPAP). Do not intubate. Generally avoid intensive care.
- ☐ COMFORT FOCUSED TREATMENT (primary goal is maximizing comfort) Use medication by any route to provide pain and symptom management. Use oxygen, suctioning and manual treatment of airway obstruction as needed to relieve symptoms. (Do not use treatments listed in full or selective treatment unless consistent with goals of care. Transfer to hospital ONLY if comfort focused treatment cannot be provided in current setting.)

ADDITIONAL ORDERS: (e.g. dialysis, etc.)

_____

_____

Medically assisted nutrition and hydration is optional when it
- cannot reasonably be expected to prolong life
- would be more burdensome than beneficial
- would cause significant physical discomfort

C. ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION: (Always offer food/fluids by mouth as tolerated)

CHECK ONE
- ☐ No artificial nutrition by tube.
- ☐ Trial period of artificial nutrition by tube. (Goal: _____)
- ☐ Long-term artificial nutrition by tube. (If needed)

D. SUMMARY

Discussed with: ☐ Patient (Patient has capacity) ☐ Personal Health Care Representative (PHCR)

The basis for these orders is:

CHECK ALL THAT APPLY
- ☐ Patient's declaration (can be oral or nonverbal)
- ☐ Patient's Personal Health Care Representative (Qualified Patient without capacity)
- ☐ Patient's Advance Directive, if indicated, patient has completed an additional document that provides guidance for treatment measures if he/she loses medical decision-making capacity.
- ☐ Resuscitation would be medically non-beneficial.
- ☐ Advance Directive dated _____, available and reviewed
- ☐ Advance Directive not available
- ☐ No Advance Directive
- ☐ Health care agent if named in Advance Directive:

Name: _____

Phone: _____

This form is voluntary and the signatures below indicate that the physician orders are consistent with the patient's medical condition and treatment plan and are the known desires or in the best interest of the patient who is the subject of the document.

PRINT PHYSICIAN'S NAME	PHYSICIAN SIGNATURE (MANDATORY)	PHYSICIAN PHONE NUMBER	DATE (MANDATORY)

PRINT PATIENT OR PHCR NAME	PATIENT OR PHCR SIGNATURE (MANDATORY)	DATE (MANDATORY)

PHCR RELATIONSHIP	PHCR ADDRESS	PHCR PHONE NUMBER

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

USE OF ORIGINAL FORM IS STRONGLY ENCOURAGED. PHOTOCOPIES AND FAXES OF SIGNED LaPOST FORMS ARE LEGAL AND VALID.

V2.06.13.2016

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

COMPLETING LaPOST

- Must be completed by a physician and patient or their personal health care representative based on the patient's medical conditions and preferences for treatment.
- **LaPOST** must be signed by a physician and the patient or PHCR to be valid. Verbal orders are acceptable from physician and verbal consent may be obtained from patient or PHCR according to facility/community policy.
- Use of the brightly colored original form is strongly encouraged. Photocopies and faxes of signed **LaPOST** are legal and valid.

USING LaPOST

- Completing a **LaPOST** form is voluntary. Louisiana law requires that a **LaPOST** form be followed by health care providers and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- **LaPOST** does not replace the advance directive. When available, review the advance directive and **LaPOST** form to ensure consistency and update forms appropriately to resolve any conflicts.
- The personal health care representative includes persons described who may consent to surgical or medical treatment under RS 40:1159.4 and may execute the **LaPOST** form only if the patient lacks capacity.
- If the form is translated, it must be attached to a signed **LaPOST** form in ENGLISH.
- Any section of **LaPOST** not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation".
- Medically assisted nutrition and hydration is optional when it cannot reasonably be expected to prolong life, would be more burdensome than beneficial or would cause significant physical discomfort.
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort focused treatment," should be transferred to a setting able to provide comfort (e.g. pinning of a hip fracture).
- A person who chooses either "Selective treatment" or "Comfort focused treatment" should not be entered into a Level I trauma system.
- Parenteral (IV/Subcutaneous) medication to enhance comfort may be appropriate for a person who has chosen "Comfort focused treatment."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective treatment" or "Full treatment."
- A person with capacity or the personal representative (if the patient lacks capacity) can revoke the **LaPOST** at any time and request alternative treatment based on the known desires of the individual or, if unknown, the individual's best interests.
- Please see links on www.La-POST.org for "what my cultural/religious heritage tells me about end of life care."

The duty of medicine is to care for patients even when they cannot be cured. Physicians and their patients must evaluate the use of technology available for their personal medical situation. Moral judgments about the use of technology to maintain life must reflect the inherent dignity of human life and the purpose of medical care.

REVIEWING LaPOST

This **LaPOST** should be reviewed periodically such as 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. A new LaPOST should be completed if the patient wishes to make a substantive change to their treatment goal (e.g. reversal of prior directive). When completing a new form, the old form must be properly voided and retained in the medical chart.

To void the **LaPOST** form, draw line through "Physician Orders" and write "VOID" in large letters. This should be signed and dated.

REVIEW OF THIS LaPOST FORM

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

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

USE OF ORIGINAL FORM IS STRONGLY ENCOURAGED. PHOTOCOPIES AND FAXES OF SIGNED LaPOST FORMS ARE LEGAL AND VALID.