Frequently Used Terms:

Code Status: a medical order that instructs healthcare providers what actions to take if your heart stops beating and/or you stop breathing.

DNR (Do not attempt resuscitation): a medical order that means if your heart stops beating and/or you stop breathing, the healthcare staff will not attempt to resuscitate you by performing CPR.

CPR: Cardiopulmonary resuscitation: CPR is used when someone's heart and/or breathing stops. CPR attempts to restart these functions. It may consist of artificial breathing, and it includes pressing on the chest to mimic the heart's actions in an attempt to restart circulation. Electric shocks and drugs may be used to stimulate the heart.

Comfort Care/Comfort Measures: Focuses on treating the symptoms of illness when cure is not possible and involves the physical, psychological, and spiritual needs of the patient.

Palliative Care: Specialized medical care for people with serious illness. Focuses on providing relief from the symptoms and stress of a serious illness with the goal to improve quality of life for both the patient and family.

Hospice or End-of-life Care: Provides comfort care for the dying patient. May be given at home, nursing home, or in a hospice facility.

Healthcare Agent/Durable Power of Attorney for Healthcare/Medical Decision Maker: Someone who makes decisions for you when you are unable to make them for yourself. This person can be recorded in an Advance Directive. If there is no written document indicating your healthcare agent, then the hospital must rely on your next of kin to make medical decisions for you.

Online Resources:

Get your copy of Georgia Advance Directive:
www.piedmont.org/patient-tools/advanced-directives

Advance Care Planning Conversation Toolkit:
theconversationproject.org

Guide to Completing the Georgia POLST:
www.gapolst.org/patients-and-families

Communicating Your Wishes:
www.caringinfo.org

With both, your wishes are covered:	POLST Form	Advance Directive
Type of document	Medical order	Legal document
Who completes?	You and your doctor	Individual
Who needs one?	Seriously ill or frail person with a life expectancy less than a year	All competent adults
Appoints a health care agent	No	Yes
What is communicated?	Specific medical orders for treatment wishes	General wishes about treatment preferences
Can be used by EMS	Yes	No
Where you keep it	Patient keeps original within reach (i.e. above bed at home, by front door). Copy in medical record.	Copies given to health care agent and other people who need to know wishes. Copy in medical records.

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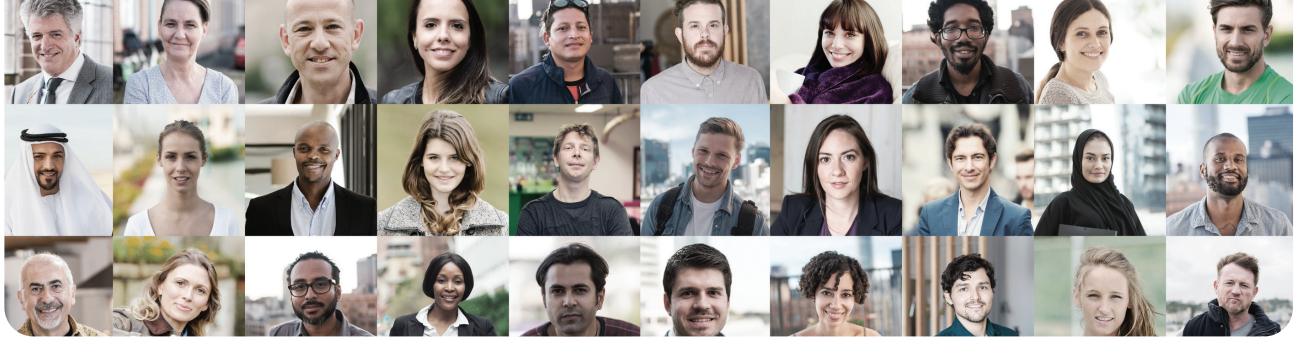
POLST

Physician Orders for Life Sustaining Treatment

Piedmont HEALTHCARE



What is an Advance Directive?

Everyone needs an Advance Directive, which provides guidance to your loved ones and health care team about your healthcare wishes if you are unable to speak for yourself.

It also allows you to:

- ✓ Choose a health care agent, who is someone to make decisions for you if you are unable to.
- ✓ Record your wishes for future medical treatment if you become unable to communicate them. Some of the decisions are about autopsy, organ donation, final disposition of your body, and life support machines.
- ✓ Choose a guardian if a court decides that you need one.

What is a POLST?

POLST stands for: Physician Orders for Life Sustaining Treatments.

Your doctor may suggest these orders if you have a life limiting illness and may die within a year. After discussing with you and/or your healthcare agent, the POLST allows the physician to create orders that respect your goals for medical treatment. These orders are portable and remain in effect whether you are in the hospital, at home or other facility. A POLST works best together with an Advance Directive.

Available Choices with a POLST:

A. Code Status: (Applies only if you have no pulse and you are not breathing.)
- Attempt Resuscitation
- Do Not attempt Resuscitation

B. Treatment Preferences: (applies while you have a pulse and you are breathing)

Comfort Care - Select this option if your goals for care are to avoid the hospital and to only receive medications and treatments that relieve pain and suffering and treat you where you are (i.e. home or facility).

Limited Additional Interventions - Select this option if your goals are to treat illnesses but only up to a certain point. For instance, you do not mind going to the hospital but would prefer not to go to the intensive care unit. Additionally, you do not want to be intubated or on a ventilator to help you breathe.

Full Treatment - Select this option if your goals are to treat any illnesses aggressively, including intubation and ventilation to help you breath; cardioversion to correct an irregular heart rhythm and other tests and treatments to prolong your life.

C. Antibiotics: You can select if and how long you want to have these treatments: None, Trial period, or Long term.

D. Artificially administered nutrition and/or fluids if unable to use your mouth: You can select if and how long you want to have these treatments: None, trial period, or long term.

Conversations with loved ones and healthcare provider over time.

All Adults

Complete Advance Directive, Name Health Care Agent

Update Advance Directive Periodically

Diagnosed with dementia, advanced illness or limited life expectancy
(at any age)

Complete a POLST form with your health care provider

Update POLST form with your provider as health status changes

Treatment Wishes Honored