

SPOST (SUMMARY of PHYSICIAN ORDERS for SCOPE of TREATMENT)

*Property of patient listed below –
Send this original with patient when transferred or discharged
Out of facility DNR requires EMS-DNR form*

SUMMARY of PHYSICIAN ORDERS for Scope of Treatment (SPOST) This form is a summary of recorded medical orders and is to be implemented when patients lack decisional capacity and their condition is life threatening. It is based on the medical condition of the patient/resident and their wishes. Any section not completed indicates full treatment for that section. When the need occurs, first follow these orders, then contact physician.

Patient	Last Name	First Name/Middle Initial	Date of Birth	
Section A Check/Initial one box only	RESUSCITATION. Patient/resident has no pulse <u>and</u> is not breathing. <input type="checkbox"/> Resuscitate <input type="checkbox"/> _____ Do Not Resuscitate (DNR) <i>Outside a facility, an EMS-DNR form is required to honor a DNR</i> Dr's initial <input type="checkbox"/> Limited <u>Do Not Resuscitate</u> (DNR) instructions: _____			
Section B Check one box only	MEDICAL INTERVENTIONS. Patient/resident has pulse <u>and/or</u> is breathing, but has a life threatening condition <input type="checkbox"/> Comfort Measures Only. The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth, and attention is paid to hygiene. Medication, positioning, wound care and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives. The patient/resident is not to be hospitalized unless comfort measures fail. <input type="checkbox"/> Limited Additional Interventions. Include care above. May include cardiac monitor and oral/IV medications. Transfer to hospital if indicated, but no endotracheal intubation or long term life support measures. Usually no intensive care. <input type="checkbox"/> Full Treatment. Includes care above plus endotracheal intubation and cardioversion. <i>Other Instructions:</i>			
Section C Check one box only	LIFE-SUSTAINING ANTIBIOTICS. Comfort measures are always provided. <input type="checkbox"/> No Life-sustaining Antibiotics <input type="checkbox"/> Administer Antibiotics as necessary <i>Other Instructions:</i>			
Section D Check one box only	ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION. Comfort measures always provided. <input type="checkbox"/> No Feeding Tube/IV Fluids <input type="checkbox"/> Defined Trial Period of Feeding Tube/IV Fluids <input type="checkbox"/> Long Term Feeding Tube/IV Fluids <i>Other Instructions:</i>			
Section E	ORGAN DONATION. <input type="checkbox"/> I do not wish to donate my organs <input type="checkbox"/> I wish to donate any organs deemed useful <i>Other Instructions:</i>			
Section F Physician's Signature Required	The preferences above were discussed with: <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Health care proxy <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Other:		Summarize Medical Condition	
	Date	Physician Phone No.		Physician Name (print)
	Physician Address:			

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Official Use Only

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Section G	<p>Patient/Resident (Parent of Minor Child) Preferences as a Guide for this POST Form</p> <p>I have given significant thought to life-sustaining treatment. I expressed my preferences to my physician and/or health care provider(s). This document reflects my treatment preferences. The following documents/persons have further information regarding my preferences:</p> <p>Advance Directive (Living Will) exists: <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>The Advance Directive is located at: _____</p> <p>A box for withholding nutrition and hydration is initialed: <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>Durable Power of Attorney for Health Care exists: <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>The following are designated in my Durable Power of Attorney for Health Care:</p> <p>Proxy #1: is _____ Telephone Number _____</p> <p>Proxy #2: is _____ Telephone Number _____</p> <p>If none designated, contact: _____ Telephone Number _____</p> <p>Court-Appointed Guardian <input type="checkbox"/> NO <input type="checkbox"/> YES Contact _____</p> <p style="padding-left: 400px;">Telephone Number _____</p>	
	<p>Signature of Patient / Resident; Parent of Minor; Guardian or Proxy (optional)</p>	
	<p>Signature of Person Preparing Form</p>	<p>Preparer Name (print)</p>
	<p>Date Prepared</p>	

Section H	<p>GENERAL CONSIDERATIONS</p> <p>COMPLETING SPOST</p> <p>Must be completed by a health care professional based on patient preferences and medical indication. Must be signed by a physician or nurse practitioner according to the nurse's scope of practice agreement.</p> <p>USING SPOST</p> <p>Any incomplete section of SPOST implies full treatment for that section. A person with capacity may always change their SPOST choices either verbally or otherwise.</p> <p>WHEN THIS FORM SHOULD BE REVIEWED</p> <p>This form (SPOST) should be reviewed periodically and if:</p> <ul style="list-style-type: none"> • The patient/resident is transferred from one care setting or care level to another, or • There is a substantial change in patient/resident health status, or • The patient/resident treatment preferences change. <p>Changes require a NEW SPOST form: write "VOID" in large letters on the front and back of the current SPOST form. After voiding the form, a new form may be completed.</p> <p><i>If no new form is completed, full treatment and resuscitation may be provided.</i></p>
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Instructions

General Instructions

This form is a *SUMMARY* of physician's orders recorded in the patient's medical record.

This form is the personal property of the patient. Just as a driver's license may be copied for informational or archival purposes, so may this form, but just as a license, the original must be transferred with the patient upon discharge.

This form must be completed with a health care provider (for example: nurse, CNA, or social worker) who can explain the implications of each section. Be sure your SPOST accompanies you to any facility you are transferred.

Section A

This section describes what is to be done if the patient's heart stops beating. *For a DNR designation to be honored, it must be initialed by the physician signing the SPOST form and supported by a DNR order in the patient's medical record. A DNR designation for an individual who is NOT in a health care facility or is transferred between facilities, must have an EMS-DNR identification attached (and meet NRS 450B.510 requirements) in order to be honored by emergency medical services. (This card is available by calling Nevada State Department of EMS: 775-687-3065)*

Resuscitate means your heart has stopped and your care providers will attempt to restart your heart using different methods including strong compressions of your chest (sometimes resulting in fractured ribs) electric shocks to the heart and a variety of drugs to try to trigger a heart beat. The longer it takes to restart the heart the greater likelihood of permanent brain damage. *If you are discharged home from a facility, you will need to apply for an EMS-DNR in order for emergency services to honor your DNR order.*

Do Not Resuscitate (DNR) means there will be no attempt to restart your heart; you will be supported and kept comfortable as death progresses. If you are not in a health care facility and you do not want resuscitation, you will need to have an out-of-hospital DNR (EMS-DNR) card in order for emergency personnel to honor your DNR order (contact Nevada State Emergency Medical Services at 775.687.3065. or visit <http://health2k.state.nv.us/ems>)

Limited Do Not Resuscitate (DNR) instructions means your care providers may try some drugs or compressions to see what effect they have, but these efforts will try to strike a greater balance of benefit to burden.

Section B

This section is consulted if a patient has a life-threatening condition, but whose heart is still beating.

Comfort Measures Only. See form for explanation.

Limited Additional Interventions means that in addition to the care described in *Comfort Measures Only* (above) care providers may also provide a heart monitor and oral/IV medications. If necessary, you may be transferred to the hospital, but no breathing tube or long term life support measures will be used. This usually means a patient will not be admitted to intensive care.

Full Treatment includes all the care listed in the two categories above plus the possibility of a breathing tube, electric shocks to the heart, kidney dialysis or surgery, or other measures your health care provider deems appropriate and necessary.

Section C

LIFE-SUSTAINING ANTIBIOTICS means that drugs that would only sustain your life, but not treat an underlying terminal disease, will not be administered. This is usually because of pneumonia, which results when the lungs are so weak they are not functioning properly. More minor infections such as a tooth abscess or infected wound would be treated with antibiotics.

No Life-sustaining Antibiotics This means that if you have a simple infection, you will receive antibiotics, but if your condition is deteriorating and you develop a serious infection that will hasten your death, you will not receive antibiotics but will receive care to keep you comfortable.

Administer Antibiotics as necessary means you will receive drugs that fight an infection that would otherwise result in death.

Section D

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION. This means a feeding tube is either inserted through the nose or surgically inserted directly into the stomach. Fluids are usually given through tubes in the arm (intravenous –IV). As we approach death our bodies often begin to shut down and we cannot digest food or absorb fluids well. If we are given food and our intestines are not functioning well, constipation occurs. If our kidneys are not working well,

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then fluid floods our tissues and we swell up. Often, there is no sense of hunger or thirst as we approach death although such sensations may occur. Comfort measures will always be provided regardless of your choice.

No Feeding Tube/IV Fluids means you will not receive artificial food or fluids through tubes.

Defined Trial Period of Feeding Tube/IV Fluids means artificial food and fluids will be started, but if there isn't much benefit, then they will be discontinued.

Long Term Feeding Tube/IV Fluids means artificial food and fluids will be provided until food and fluid can be taken again by mouth or death occurs.

Section E

This section allows you to declare if you would like to offer your organs for donation.

Section F

Note: This section is to be completed by the care provider, who assists in completing this form, and your physician

Section G

Note: This section should be completed by the care provider assisting with this form. Be sure to carefully transfer information concerning the patient's Advance Directive (Living Will) and Durable Power of Attorney for Health Care onto the SPOST form. If the patient expresses wishes to make changes to either of these documents, those cannot be initiated on the SPOST form, they must first be made to the original documents, signed, witnessed and then transferred to the SPOST form. Remember, the SPOST is only a *SUMMARY* of existing documents.

This section tells your care provider about documents to locate and people to contact in case of an emergency. Be sure to complete any part of this section that applies. If you haven't already, be sure to share the choices you've made on this form with any proxies you've designated in your Durable Power of Attorney for Health Care. It is *extremely* important that your proxies know what your wishes for end-of-life treatment are; be sure to share this information with them. The state approved Nevada Durable Power of Attorney for Health Care can be obtained by contacting the Nevada Center for Ethics and Health policy at www.healthethics.org or calling 775-327-2309.

Your signature in this section verifies that you have made the decisions reflected on this form. Be sure to sign this section and if anyone has helped you complete it, have them complete the Preparer's information boxes.

Section H

This section describes general use of the SPOST and the process used in case another SPOST form is completed at some point.

This form (POST) should be reviewed periodically and definitely if:

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

If this form is to be voided, write "VOID" in large letters on the front and back of the form. After voiding the form, a new form may be completed. *If no new form is completed, full treatment and resuscitation may be provided.*

Once completed

Patients in a health care facility: *This form should be in a readily accessible location and produced when EMS is summoned, either above a patient's bed in an envelope clearly labeled SPOST or at the very front of the patient's chart. As well, the chart should be coded on its binding indicating a SPOST is available. Always send the original SPOST with a patient transfer.*

Persons outside health care facility: *At home this form should be located in a prominent place. We suggest placing it in a large manila envelope (so it isn't folded) and hanging it on the front of the refrigerator or above the person's bed with SPOST printed plainly on the outside.*

If you have any questions about the SPOST form, its completion or use, contact the Nevada Center for Ethics and Health Policy, 775-327-5708, ncehp@unr.edu.